Overview
Allergy testing is performed to determine a patient's immunologic sensitivity or reaction to particular allergens for the purpose of identifying the cause of the allergic state, and is based on findings during a complete medical and immunologic history and appropriate physical exam obtained by face-to-face contact with the patient.

Guidelines
Sublingual intracutaneous and subcutaneous provocative and neutralization testing and neutralization therapy (Rinkel Test) for food allergies are excluded from Medicare coverage because available evidence does not show that these tests and therapies are effective. This exclusion was published as a Final Notice in the "Federal Register" on September 29, 1988.

APPLICABLE CODES

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

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<td>ICD-10 Diagnosis Code</td>
<td>Description</td>
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<tr>
<td>Z83.2</td>
<td>Family history of diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism</td>
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<tr>
<td>Z83.3</td>
<td>Family history of diabetes mellitus</td>
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<td>Z83.41</td>
<td>Family history of multiple endocrine neoplasia [MEN] syndrome</td>
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<tr>
<td>Z83.49</td>
<td>Family history of other endocrine, nutritional and metabolic diseases</td>
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<tr>
<td>Z83.511</td>
<td>Family history of glaucoma</td>
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<tr>
<td>Z83.518</td>
<td>Family history of other specified eye disorder</td>
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<tr>
<td>Z83.52</td>
<td>Family history of ear disorders</td>
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<tr>
<td>Z83.6</td>
<td>Family history of other diseases of the respiratory system</td>
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<tr>
<td>Z83.71</td>
<td>Family history of colonic polyps</td>
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<tr>
<td>Z83.79</td>
<td>Family history of other diseases of the digestive system</td>
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<td>Z84.0</td>
<td>Family history of diseases of the skin and subcutaneous tissue</td>
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<tr>
<td>Z84.1</td>
<td>Family history of disorders of kidney and ureter</td>
</tr>
<tr>
<td>Z84.2</td>
<td>Family history of other diseases of the genitourinary system</td>
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<tr>
<td>Z84.3</td>
<td>Family history of consanguinity</td>
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<tr>
<td>Z84.81</td>
<td>Family history of carrier of genetic disease</td>
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<tr>
<td>Z84.89</td>
<td>Family history of other specified conditions</td>
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<td>Z91.010</td>
<td>Allergy to peanuts</td>
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<tr>
<td>Z91.011</td>
<td>Allergy to milk products</td>
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<td>Z91.012</td>
<td>Allergy to eggs</td>
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<td>Z91.013</td>
<td>Allergy to seafood</td>
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<td>Z91.018</td>
<td>Allergy to other foods</td>
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<td>Z91.02</td>
<td>Food additives allergy status</td>
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**PURPOSE**

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers’ submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:
- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as LCDs, NCDs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

**REFERENCES**

**CMS National Coverage Determinations (NCDs)**

NCD 110.11 Food Allergy Testing and Treatment

**CMS Local Coverage Determinations (LCDs)**

<table>
<thead>
<tr>
<th>LCD</th>
<th>Medicare Part A</th>
<th>Medicare Part B</th>
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<tr>
<td>L32553 (Allergy Immunotherapy) CGS</td>
<td>KY, OH</td>
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<td>L33261 (Allergy Testing) First Coast</td>
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<td>L33417 (Allergy Skin Testing) Palmetto</td>
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<td>L34313 (Allergy Testing) Noridian</td>
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<td>AS, CA, GU, HI, MP, NV</td>
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<td>L36240 (Allergen Immunotherapy) Novitas</td>
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Food Allergy Testing and Treatment (NCD 110.11)  
UnitedHealthcare Medicare Advantage Policy Guideline

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<td>IA, IN, KS, MI, MO, NE</td>
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**CMS Benefit Policy Manual**  
Chapter 15; § 20.2 Physician Expense for Allergy Treatment, § 50.4.4.1 Antigens  

**CMS Claims Processing Manual**  
Chapter 12; § 200 Allergy Testing and Immunotherapy

**GUIDELINE HISTORY/REVISION INFORMATION**

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
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<tbody>
<tr>
<td>04/15/2019</td>
<td>• Reorganized policy template; relocated Terms and Conditions and Purpose section</td>
</tr>
<tr>
<td></td>
<td>• Reformatted list of applicable ICD-10 diagnosis codes</td>
</tr>
<tr>
<td>12/12/2018</td>
<td>• Annual review for MAPG Committee presentation and approval</td>
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**TERMS AND CONDITIONS**

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication, and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

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*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.